My Body, My Choice: Latina Sterilization in the U.S. & Questions of Choice

A Thesis in Women's and Gender Studies

by

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Abstract

The ability for a woman to make her own choices regarding her body has always been central to the fight for reproductive rights. However, for Latinas within the United States, reproductive choice continues to be complex struggle. For instance, throughout the 1900s, the United States influenced Puerto Rican legislation surrounding birth control to primarily promote sterilization. In the 1970s, Mexican-origin women were forcibly sterilized in a Los Angeles hospital. Observed since the 1970s, Latinas in the United States exhibit higher rates of sterilization. These are not isolated phenomena; rather, they are exemplary of racism and sexism at work within medical institutions. This project means to suggest that the historical relationship between Latinas and sterilization within the United States serves as a prime example of the manner in which Latina bodies are constructed and minimized to the point of naturalizing and justifying violence. Drawing links between historical events and contemporary sterilization rates, sterilization becomes a focal point of analysis to understand the construction of Latina bodies and formulate a conclusion about the failures of reproductive healthcare. Combining the discourse of existing feminist theory and medical ethics, this project grapples with definitions of sterilization abuse, agency and autonomy, ultimately complicating the dichotomous model of choice through a critical, intersectional perspective.

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INTRODUCTION

When you carry the potential of birthing new human life, you are also cursed to carry the burden of vulnerability. The ability for a woman to make her own choices regarding her body has always been central to the fight for reproductive rights, as women fight against the vulnerability that the female gender has attached to it. However, for Latinas within the United States, reproductive choice is complicated beyond just an issue of gender. Living in a body additionally carrying inscriptions of both race and gender, Latinas are forced to exist in a different kind of vulnerable position. The capability to bear children and produce the next generation becomes something to fear when associated with particular types of women. When medicine becomes a reflection of dominant societal beliefs, such as a fear of "Others" tainting society, scientific procedures become the vehicle for forwarding discriminatory agendas in the name of societal maintenance.

This thesis primarily focuses on sterilization as a focal point of analysis to understand the construction of Latina bodies. By suggesting a correlation between historical instances of sterilization abuse and contemporary sterilization rates in the United States, this project highlights the manner in which Latina bodies are constructed and minimized to the point of naturalizing and justifying violence. The reproductive histories of Mexican and Puerto Rican women within the United States exemplify how and why Latina bodies become mandatory sites of control. These two ethnicities are two of the most dominant in the United States; while they do not represent the entirety of the

Latina demographic, theorizing from their experiences starts to lay down the groundwork for future of discourse surrounding Latina specific reproductive healthcare.

In isolation, sterilization is a medical procedure that removes the patient's reproductive capabilities; however, social stigma is emblazoned on this procedure when being performed on patients of a certain background as a means of social control. Scholars argue that a correlative relationship exists between histories of reproductive abuse and present day reproductive healthcare (Gutiérrez 2008; Leyser-Whalen and Berenson 2015; Lopez 2008). However, the reasons for certain statistics have yet to be identified and articulated -- two crucial steps for any kind of healthcare improvement. In particular, the reproductive history and current reproductive situation of Latinas reveals a more complex issue with the theoretical foundation of medicine and its impact on physical outcomes.

The reproductive history of Latinas in the United States informs this observation, years of sterilization abuse presenting a resilient social construction of Latina bodies that persists in contemporary times (Gutiérrez 2008; Leyser-Whalen and Berenson 2015; Lopez 2008). Statistics show that Latina/Hispanic women are more likely than white women to opt for sterilization as a form of birth control (Leyser-Whalen and Berenson 1115; Shreffler et al. 34). Between 2011 and 2013, the National Center for Health Statistics and Center of Disease reports female sterilization as the second most common contraceptive method amongst all women[1]. Within this, statistics show that

[1] The most common contraceptive methods for women aged 15-44 reported by the CDC/NCHS in the United States, 2011-2013, are as follows: oral contraceptive pill (16.0%), female sterilization (15.5%), condoms (9.4%) and long-acting reversible contraceptive (7.2%).

Hispanic/Latina women had a higher rate of female sterilization than non-Hispanic/Latina white women[2]. Similar trends are reported in older studies conducted with the United States, as Hispanic/Latina are found to have higher rates of sterilization use[3]. Additionally, socioeconomic status and sterilization use have been found to have an inverse relationship; with increased socioeconomic status comes decreased sterilization use (Jones et al. 12). These differences are not coincidence, as these trends continue further back in time, continuously existing alongside nasty public rhetoric surround Latina reproduction and sexuality. Deciphering Latina sterilization trends over time works to expose the impact of factors such as race, ethnicity and gender on both the delivery and outcome of reproductive healthcare. Observing contemporary sterilization rates in isolation lacks informed analysis of the roots of Latina sterilization, specifically why such a procedure would demonstrate more popularity with a particular race/ethnicity. The answer lies in working through the social construction of Latina bodies.

A theoretical and historical approach to the question this project poses requires the combination of voices, primarily emerging from areas such as feminist thought and medical ethics. Works by well known women of color within feminist scholarship such as Kimberle Crenshaw and Gloria Anzaldúa assist in characterizing Latina lives through intersectionality, a well established strategy promoted by women of color in the

[2] The CDC/NCHS report that in the United States, 2011-2013, the use of female sterilization among Hispanic/Latina women was 18.8%. For non-Hispanic/Latina white women, the rate was 14% and 21.3% for non-Hispanic/Latina black women.

[3] Between 2006-2010, the CDC/NCHS report that 27% of Hispanic/Latina US born women between the ages of 15-44 have been sterilized, 37% of Hispanic/Latina foreign born women have been sterilized, compared to 24% for non-Hispanic/Latina women.

reproductive justice movement. Scholar Kimala Price best characterizes the ideological differences between reproductive rights and reproductive justice, as it relates to the poor treatment of women of color and their reproduction. Additionally, theorists such as Patricia A. Kinser and Judith A. Lewis explore the role of gender and race in healthcare and its resulting health disparities.

Key theorists creating a bridge between feminist thought and medical ethics include Rosalind Pollack Petchesky and Lena Hankivsky, who synthesize the concepts between these areas to create shared concepts such as bodily autonomy and agency as it relates to medical decisions. Petchesky is particular rejects classic liberalism's model of choice, rather emphasizing the relationship between the individual and social interdependence, especially with regards to reproductive decisions. Hankivsky pushes for the incorporation of intersectional thinking in medical ethics in order to better understand and serve patients, and address prevalent health disparities. These scholars, and many others, present the framework in which Latinas are constructed as Others and how this relates to high sterilization rates.

Because this project aims to explore Latina reproductive agency and autonomy in relation to sterilization, I will only be analyzing instances of sterilization after its legalization as a method of birth control. Presenting sterilization as a voluntary contraceptive method gives greater significance to the way in which gender, class, race and ethnicity shape reproductive healthcare practices and outcomes. The framing of Latinas as unwanted reproducers is exemplified throughout the rhetoric of population control and poverty alleviation, as both Iris Lopez and Elena Gutiérrez present within

their respective works retelling the reproductive histories of Puerto Rican and Mexican women. These scholars in particular have began to make the connection between high contemporary sterilization rates and histories of sterilization abuse for these particular ethnicities. However, these project synthesizes these texts through a theoretical framework to generate Latina specific definitions of reproductive agency and autonomy. Puerto Rican and Mexican women are only some of the Latina population within the United States that have been targeted by ideologies of colonialism, gender, race, ethnicity and class. These ideologies in conjunction mark the foreign Latina body as dangerous, as a problem, as a societal contagion to be addressed.

The United States is meant to be a melting pot of identities, a land of opportunity, but bodies are still marked and categorized, doomed to manipulation and violence that is naturalized and justified. Organizations such as the Center for Disease Control and Healthy People 2020 recognize the correlation between social conditions and health. Both organizations attribute disparities in health as a result of social determinants of health, which is defined as, "conditions in the environments in which people live, learn, work, worship, and age that affect a wide range of health, function, and quality-of-life outcomes and risks" (Healthy People 2020). Examples of these determinants include race/ethnicity, class, cultural factors and socio-economic factors and often are reflected in policy choices. While these determinants refer to very broad definitions of health and healthcare, they are still applicable to the specifics of reproductive healthcare and all come into play when discussing Latinas. Further examples of social determinants given by these big name organizations include language and literacy, social support and quality of education

and job training (Healthy People 2020) – all of which are applicable in a discussion about the state of Latina reproductive healthcare, historically and currently. Latina experiences of sterilization abuse exemplify social determinants of health at work. A theoretical approach takes the recognition of these disparities further by developing a framework that can be utilized to address such violent discrimination.

Women as a collective group may have a shared generalized history of mistreatment by healthcare professionals and institutions, but these experiences of healthcare and medicine are considerably worse women of minority backgrounds (Gutiérrez 2008; Hankivsky 2011; Leyser-Whalen and Berenson 2013; Lopez 2008; Price; 2009; Vigen 2006). Applying an intersectional feminist lens to the world of health generates an important conversation about how Latina bodies are physically viewed and handled. In place are oppressive systems that warp the social and scientific standards of healthcare practices that can only be addressed through an awareness of where those oppressions intersect and the resulting consequences. If reproductive rights is at the intersection of sex and gender (Baer xii), then Latina reproductive rights is at an even more crowded intersection of sex, gender, race and ethnicity.

By utilizing the language of medical ethics and attempting to discerns a concrete notion of Latina reproductive agency, this project presents a presents a synergy of interdisciplinary thought around the very concept of reproductive choice. Questions of sterilization abuse are expanded upon and complicated, taking from the arguments about when reproduction is valued and by whom. Breaking down the social construction of Latinas and then tracing it through history assists in building bridges to close the gaps in

existing discourse surrounding Latina reproduction, critiquing and invalidating external forces exerting control and assigning worth to bodies without logic or justice.

CHAPTER ONE: THEORETICALLY CONSTRUCTING THE LATINA BODY

A theoretical framework needs to be established in order to begin to break down sterilization as a medical procedure with sociopolitical significance. Feminist theory provides concepts to develop a lens to achieve this. Within this project, these key concepts primarily consist of intersectionality, agency and autonomy. These interdisciplinary concepts are found in the discourse of areas beyond feminism, allowing for the possibility of synthetic dialogue. When discussing Latina sterilization, medical ethics need also be brought into the conversation in order to further theorize intersectionality and agency within that framework. This chapter is structured to support an analytic process that moves from macro to micro, generating a lens to be applied in the evaluation of Latina sterilization throughout history.

A solid understanding of intersectionality informs not only what defines agency for Latinas, but more specifically what defines Latina reproductive agency. This differentiation is necessary when addressing sterilization and its repercussions, both in cases of consent and coercion. Definitions of agency are formed by theorizing from actual experiences; because Latinas have had different reproductive experiences, defining a concept such as reproductive agency then takes a different route of greater specificity. This logic can be found in the rhetoric of feminists of color and the reproductive justice movement, but there still lacks a perspective specifically catering to Latina reproductive experiences. Feminist scholarship begins to illuminate the structural reasons for

disparities among Latina reproductive healthcare, especially in regards to disparities among sterilization experiences. Before honing in on reproductive healthcare experiences, feminist theory takes a more macro approach in addressing general variances of experiences amongst women, explaining why these differences emerge. Female lives are asymmetrically shaped due to factors besides gender, such as race/ethnicity and class, which cannot be studied in isolation. These identity factors all coincide and mutually construct one another in the realities of women's lives. This intersectional understanding works to generate a feminist observation of differential and therefore discriminatory healthcare practices and beliefs that has lead to the unfortunate reproductive history of Latinas in the United States.

In order to locate where marginalization places and constructs the Latina body, I will consider key texts from within the scholarship of feminism, which includes works from scholars such as Kimberle Crenshaw and Gloria Anzaldúa. These texts act as the foundation of analyzing Latina sterilization by mapping out the sociopolitical context of Latinas within society as both women and people of color. This theory is then supplemented by an exploration of gender and race within healthcare by scholars such as Patricia A. Kinser and Judith A. Lewis, among others. Paralleling the agenda and ideology of the reproductive justice movement, all these intersectional theoretical components fill in the gaps left by existing attempts to merge feminism and medical ethics theory, ultimately generating a notion of reproductive agency unique to Latina reproductive healthcare.

The process of "othering" is traced in order to gauge its impact on reproductive healthcare and attitudes surrounding associated concepts, such as sexuality. Race and ethnicity becomes the base of otherness and differential treatment as various feminine stereotypes revolving around sexuality and reproduction support such social beliefs. Stereotyping creates a homogenized Latina body that does not really exist, but is lived out in the physical realities of Latinas across the U.S. While the Latina body is marked as dangerous, these images and ideologies also work to control the reproductive and sexual choices of Latinas by ultimately impacting the construction of health institutions. This othering process becomes key in the discussion of sterilizing Latina bodies, especially when considering the influence that the othering rhetoric has on nonscientific beliefs of Latina reproduction.

The "otherness" of the Latina vilifies her sexuality, fertility and reproductive capabilities, causing the development of reproductive healthcare that caters to public anxiety about Latinas, not Latina patients themselves. The concept of otherness develops itself within the genealogy of the feminism of women of color, eventually moving itself into the more specific construction of Latinas. While the history of Latina reproductive healthcare within the context of the United States is very similar to other groups, such as Black women, the construction of these bodies is different and must be acknowledged as such. Additionally, the marginalization of the reproductive Latina body is radically different from that of white women, even though both groups have suffered reproductive injustices as a result of gender discrimination.

Reworking the process of othering entails recognizing the role that race, class, ethnicity and gender all play in the Latina experience of discriminatory reproductive healthcare. History informs the way in which reproductive healthcare practices have been used as a biased vehicle. The theoretical concepts found in the discourse of Latina feminism provide the tools to rework these concepts in a positive manner to recognize differences in identity, and therefore experience. Simply the application of a feminist approach to reproductive healthcare and the associated ethical issues is insufficient. Much of feminist thought equates to views of Western white feminism, the predominant group producing feminist scholarship. The reasoning for this needs little explanation – systems such as racism and classism contribute to the hierarchies of inequality within this field of study. Often missing from criticism of reproductive healthcare is a diverse representation of female reproductive experiences because differential identity factors are not taken into account.

The Importance Of Intersectional Thinking

The shift within feminist discourse from addressing just one general female experience to an acknowledgement of variety within these experiences is marked by the incorporation of intersectional thinking (Mohanty 18). While the term "intersectionality" was not coined until the 1990s by Kimberle Crenshaw, this thinking became present in the ideology of feminists of color long before it had a name. The genealogy of feminist thought between women of color bases itself in identity specifics, working against the overgeneralization of a more dominant, mainstream feminist discourse that ultimately

silences oppressive experiences and leaves them invisible and unaddressed (Mohanty 9). The specificity that intersectionality promotes is a key component of addressing negative experiences that individuals have had in order to identify the forces at work. In the case of Latina reproductive healthcare, particularly sterilization, intersectional thinking acts as a tool that pays explicit attention to the role that race and ethnicity play, alongside gender and class, in shaping negative experiences, therefore uncovering discriminatory motives.

Texts by Crenshaw such as "Mapping the Margins: Intersectionality, Identity Politics, and Violence Against Women of Color" support the application of intersectionality to address women's issues, especially that of women of color. She locates women of color at the intersection of race, class and gender, a location of oppression and structural violence (Crenshaw 1243). Crenshaw's exploration of violence against women of color can be applied directly to the issue of poor reproductive healthcare. She accepts the intersecting experiences of racism and sexism, arguing that such recognition is necessary in order to avoid the conflation of identity politics (1242). While Crenshaw's work primarily focuses on the black experience, her theory of intersectionality applies to the experiences of all women of color. Her proposed method of an intersectional approach relates itself to the incorporation of identity in reproductive healthcare as a means of catering specifically to Latina patients, responding to a history of normalized racism and sexism. This explicit concentration does not separate factors such as gender, race or ethnicity into isolated entities, rather recognizing how they work in conjunction to impact lives beyond individual control.

There is a vulnerability created for women of color in the United States, a status that is structurally reinforced. Crenshaw states: "Intersectional subordination need not be intentionally produced; in fact, it is frequently the consequence of the imposition of one burden that interacts with preexisting vulnerabilities to create yet another dimension of disempowerment" (1249). Patterns of subordination – a phrase borrowed from Crenshaw – apply specifically to the case of Latina reproductive healthcare concerning issues such as language barriers, poor access to information, and economic disadvantages (Healthy People 2020; Vigen 2006). Because Latina bodies are constructed differently than white bodies, their marginalization places them in a location within society where reproductive healthcare is less effective and ultimately hurtful. The location of this particular identity cannot be explained by race, ethnicity or gender alone – only an intersectional approach considering all three will even begin to get the bigger picture of the problem at hand. Class is an additional factor, as poor economic standing is both a common Latina experience and therefore an additional vulnerability. To omit these identity factors invalidates the violence against women of color such as Latinas, who have a history of violence against their reproductive and sexual capabilities, as exemplified through repeated events such as forced sterilization. In addition, an intersectional approach explores the complexity around statistics such as high sterilization among Latinas as a form of birth control.

The need for intersectionality in medicine is acknowledged by scholars outside of feminism, as presented within Lena Hankivsky's "Rethinking Care Ethics: on the Promise and Potential of an Intersectional Analysis." Intersectionality as an analytic tool

takes into consideration the many layers of everyday life – micro, meso and macro – as well as time and space, complicating traditionally simplistic understandings of social construction (Hankivsky 255). In addition, the concept of intersectionality continuously works to dissolve static representations of identities and social locations through a rejection of *a priori* analytic prioritization of any identity category (Hankivsky 256). Hankivsky additionally states:

> Such an [intersectional] analysis requires an appreciation of how such relationships and concomitant distributions of advantage and disadvantage have developed historically and exist contemporarily, and how they can be transformed to create the conditions of a more socially just world (255).

Intersectionality aides in the breakdown of how bodies are constructed, becoming especially relevant when considering the mutuality between theoretical constructions and the physical handlings of a body. Therefore, the application of intersectionality when dealing with patients of color works considerably different than discrimination, with discriminatory healthcare using factors such as race, ethnicity and gender as prerequisites of justification of poor treatment. Instead, a feminist approach works against the invisibility that Crenshaw identifies, resisting marginalization and replacing it with the act of providing patients such as Latinas with an attention meant to reduce disparities. The negative construction of Latina bodies starts to fall apart when applying an intersectional analysis to uncover discriminatory and oppressive stereotypes; when systems of oppressions are acknowledged and identities begin to reconfigure themselves.

Rethinking Anzaldua's Borderlands

Gloria Anzaldùa's iconic piece *Borderlands*/*La Mestiza* provides the tools to locate the Latina body in the Borderlands – a theoretical, oppressive location. This text

heavily considers the construction of Latino identity, theoretically and in physical reality. While Anzaldúa bases this work on her own personal experience of her Chicana [4] identity, this text has been extended to apply to the general Latina experience. The Borderlands is a location of conflict – between cultures, identities, and worlds. Anzaldúa states: "Borders are set up to define the places that are safe and unsafe, to distinguish *us* from them…. A borderland is a vague and undetermined place created by the emotional residue of an unnatural boundary… The prohibited and forbidden are its inhabitants" (25). To be located here is to be cast off and reduced, invalidated, erased, silenced. It is a position decided by phenomena such as colonization, which utilizes processes such as racism and sexism as a means to control foreign bodies. These oppressive social barriers can be found in the construction of reproductive healthcare in terms of constructing the foreign Latina body as something to be colonized, controlled and compartmentalized. Colonization justifies the promotion of systems of inequality by labeling certain groups as inferior others.

This piece predates Crenshaw's theory of intersectionality, as Anzaldua published *Borderlands* in 1987, but clearly encompasses intersectional thinking. The Borderlands location takes into consideration the various entities that factor into the marginal location a Latina woman such as in that which Anzaldua finds herself. This piece predates Crenshaw's theory of intersectionality, as Anzaldua published *Borderlands* in 1987, but clearly encompasses intersectional thinking. The Borderlands location takes into

[4] Chicana refers to a Mexican-American, while Latina refers very broadly to anyone with Latin American origins. Anzaldúa's *Borderlands* is highly autobiographical and so her text is very specifically focused on Chicano identity and culture, working through Mexican history in relation to the United States.

consideration the various entities that play a factor in the marginal location a Latina woman such as Anzaldua finds herself in. Through theorizing her own experiences and those associated oppressions, Anzaldua identifies components beyond just gender, beyond just race or ethnicity, but instead proposes a combination of all of these and more. The Borderlands theory becomes essential in the addressing of Latina reproductive healthcare because of its clear mapping of the influences constructing Latina lives. The social construction of Latinas has a direct correlation with how their physical bodies are handled and the level of agency they are allowed to make autonomous decisions. In other words, the Borderlands theory is also a question of Latina agency, in terms of mobility and the realities of choice.

The theory of the Borderland pushes for decolonized thinking, calling for a rethinking and reconstruction of the social location that Latinos/as are placed in within the context of the United States. Naming it *la mestiza*, Anzaldúa explains:

> La *mestiza* constantly has to shift out of habitual formations; from convergent thinking, analytical reasoning that tends to use rationality to move toward a single goal (a Western mode), to divergent thinking, characterized by movement away from set patterns and goals and toward a more whole perspective, one that includes rather than excludes (101).

This thinking is essential in the development of a theoretical framework that rights the wrongs of American reproductive healthcare for Latinas. In essence, the concept of *la mestiza* allows for new voices to be heard, moving in the direction of a reallocation of power and priority.

While this rejected location is not a literal, physical location, this theoretical space manifests itself physically because it is so very much based on the literal body. This

theoretical location physically inscribes itself through its social construction of brown, foreign bodies. Anzaldùa's Borderlands describes this as a shared process for marginalized peoples:

> The struggle is inner. Chicano, *indio*, American Indian, *mojado, mexicano,* immigrant Latino, Anglo in power, working class Anglo, Black, Asian – our psyches resemble the bordertowns and are populated by the same people. The struggle has always been inner, and is played out in the outer terrains. Awareness of our situation must come before inner changes, which in turn come before changes in society. Nothing happens in the "real" world unless it first happens in the images in our heads (109).

By locating the struggle as an internal process that manifests itself outside of the body, Anzaldúa suggests a potential strategy for resistance and solution. If the issue at hand is the inner construction of marginalized identities – in this case, it is the reproductive, sexual Latina body – then only through a rethinking of this space, this identity, can a strategy for improvement be achieved. This logic is complimentary with the concepts of feminism broadly arguing for retheorizing bodies in reproductive discourse, but tightens the focus on the Latina situation.

Applying the notion of internal struggle further complicates the decisions of Latinas who voluntarily opt for sterilization, in comparison to forced sterilization. Anzaldua's theory suggests oppressive influence comes in both blatant and subliminal forms, therefore complicating the very definition of Latina agency and what it entails. The Borderlands responds to the specifics of Chicana identity, but presents processes of marginalization applicable to other Latino ethnicities. There is a shared struggle amongst the many races and ethnicity that make up the Latinx demographic, especially with regards to sterilization. The narrative around reproductive choice is further complicated

when attempting to expand definitions of sterilization abuse to incorporate more subliminal forms of societal influence.

The Borderlands theory lays down the foundational work not only for Latina feminist theory, but also for the development of the theoretical framework necessary to address the issue of how race and ethnicity has negatively affected Latina reproductive healthcare by justifying and normalizing harmful practices. The Borderlands theory works well to identify the marginalization of Latinas and how otherness is established and maintained. To rethink the Latina body as the space that the Borderlands theory describes therefore presents the Latina body as a space for physical and theoretical reclamation by rewriting dominantly constructed narratives. However, additional voices need to come into conversation in order to cover the full scope of how this otherness is inscribed on the reproducing Latina body. Without explicitly saying it, texts such as Anzaldùa's contains criticism of social constructionism, biological determinism, and other related oppressive systems. However, this theory can only be reworked so much to be applicable to the issue of poor reproductive healthcare before requiring more substantial theorizing about gender, race, and ethnicity within healthcare. The Borderlands theory is a crucial component to understanding the specific gendered construction of Latina bodies, but alone does not provide central definitions of reproductive agency and bodily autonomy, especially when attempting to challenge certain dichotomies of choice.

Gender and Race Within Healthcare

The development of reproductive healthcare overtime is difficult to analyze without additional context, Simone M. Caron argues in, "International Perspectives on Reproductive History." She states, "one consistent theme in the history of reproduction over the intervening decades has been how closely tied reproduction is to population control and state agendas" (184). This is a trend recognized not only within the United States, but also within various countries and cultures as an attempt to control bodies. The recognition of this characteristic of the history of reproductive healthcare pushes for the implication of cultural sensitivity to reach "a diverse socio-economic, racial, and ethnic group of women" (Caron 193). Feminism's focus on reproductive health involves considering how factors such as gender impact the determination of female health, as it relates to issues such as access to resources and the quality of those resources. However, what is continually lacking is an intersectional gaze that readjusts with each new identity. To acknowledge the struggles of all women of color and reproduction is one thing, but even within that broad group poor experiences of reproduction continue to differ. Additionally there is concern around framing reproductive health and its related components: sexuality, motherhood, even womanhood as a whole. This issue further complicates itself with the inclusion of intersectional thinking. Caron recognizes that the current state of reproductive healthcare is still greatly flawed, but contends that there are greater numbers of feminist organizations that intend to promote female health on local, national and global scales (193). The organizations that Caron uses as examples have agendas that cover a large range of issues, addressing sexual and reproductive rights, access to healthcare, and other policy related issues. This promotion, however, fails to

address the complex reproductive barriers that face women whose lives are burdened beyond just their gender.

The awareness of gender disparities within healthcare practices is only one piece of the larger issue of inadequate Latina reproductive healthcare. However, it is only by first understanding the role of gender in healthcare that the construction and care of Latina bodies can be better understood. Mainstream feminist scholarship explores the negative consequences of gender in health, an idea presented by Patricia A. Kinser and Judith A. Lewis in, "Understanding Gender Construction: Creating Space for Feminist Health Care Practice and Research." Kinser and Lewis attempt to trace the conceptualization of female biological inferiority and how this relates to the construction of healthcare, ultimately arguing, "cultural assumptions influence the institution of scientific inquiry and vice versa" (423). Feminists believe that equal and fair healthcare practices can be achieved only by first rejecting culturally dominant methods in medicine and science, instead embracing feminist concepts (Kinser and Lewis 423). This methodology acknowledges the historical social bias actively embedded in scientific and medical medical institutions. These social biases emerge from systems of gender, race, and ethnicity; however, Kinser and Lewis focus specifically on the conceptualization of gender based in an essentialist argument of biological sex difference.

Early thinkers such as Aristotle and Galen theorized a biological explanation for female inferiority, using the male body as the standard, "perfect" human body and the female body in comparison being constructed as a defect body (Kinser and Lewis 424).

These early theories set precedence for the future of scientific research by justifying biological essentialism. Kinser and Lewis state:

> …the use of these [biological] differences to justify distinctions in healthcare and biomedical research perpetuates the imposition of gendered stereotypes; furthermore, it may ignore the racial, ethnic, educational, occupational, and social class divisions within the genders. Indeed, diversity itself is a social construct, not a genetic absolute (425).

Differential healthcare as it stands, with history and current institutions acting as evidence, has little to do with the biological necessity of differential care. While the biological differences between men and women allows women a healthcare all their own – reproductive health – these biological differences support the inequalities perpetuated by gender as a system, constructing female bodies as inferior to men and therefore vulnerable to larger social control. These vulnerabilities become apparent when women are not the ones make decisions regarding their bodies.

The push for a feminist science involves moving away from patriarchal bias. A portion of this solution lies in more women being involved in medicine and science. However, in the case of reproductive healthcare rethinking the cultural beliefs and interests that contribute to the construction of bodily theorizing is also needed. Scientific discourse, historically and currently, is bogged down by negative cultural assumptions, shaped heavily by gender and its oppressive nature (Kinser and Lewis 428). Kinser and Lewis explain: "Feminist health care and research contends that an understanding of patients' social and environmental contexts…is essential. Awareness of sexist, racist, homophobic, and other stereotypical underpinnings is the first step toward neutral and effective science" (428). While Kinser and Lewis' argument is intended as a broad

critique of scientific and medical institutions, it can still be utilized to discuss the flaws of women's healthcare. Their discussion of the historical inclusion, justification, and function of gender within healthcare gives a general framing of the social context of health, therefore generating a holistic perspective of health.

The incorporation of traditional gender ideologies in reproductive healthcare normalizes and justifies harmful female stereotypes. In "Unethical Female Stereotyping in Reproductive Health," authors Rebecca J. Cook, Simone Cusack and Bernard M. Dickens link adherence to traditional gender roles to the narrative around reproductive healthcare. For a female patient receiving reproductive healthcare, the immediate assumption is motherhood, but the capability of motherhood immediately renders the female patient vulnerable to outside intervention seeking to have a say in what that motherhood looks like. Female stereotypes from traditional gender ideology normalizes reproductive healthcare that place female patients in a submissive position, with limited resistance to dominant oppressive beliefs. The authors argue:

> When stereotypes are prescriptive, they can be unethical and unlawful; that is, when they are applied to prescribe what individuals must do, or must not be permitted to do. Laws, policies, and practices, for instance, that condition or confine women to mothering or domestic roles, or that prevent women's exercise of reproductive self-determination, have unfortunately been persistent in reproductive and sexual healthcare (Cook et al. 256).

This article in particular is looking at very general female stereotypes. There is a lack of acknowledgement of the variety of female stereotypes that exist when taking into account race, ethnicity, or even class. The authors do, however, make the link between structural and social mutually influencing, maintaining, and constructing one another through stereotypes Cook et al. 257). The diminishment of female agency is rigidly inscribed in

institutions, normalizing the oppressions that women face when seeking reproductive and/or sexual health assistance.

Issues revolving around reproduction and sexuality are considerably complex in composition, composed of dense theoretical frameworks and differential language based on locational context, as the authors of *Introduction: Contextualizing "Right" In Sexual and Reproductive Healthcare* assert. The language of sexual and reproductive health and rights differs considerably when generating discourse from lived experiences versus a hypothetical, universal notion of rights (Standing et al. 1). Shifting the perspective of this particular conversation better illuminates the role of these rights in everyday life. The broadness of macrolevel reproductive discussion can be explained by ethnic discrimination varying by historical and geographic context, as the discrimination against Latinas in the United States can be explained and traced throughout history. The themes presented by international perspectives of reproductive justice or rights, however, still relate themselves to the context of the United States. The authors explain that, "individual politics of reproductive and sexual behavior and associated 'rights' are embedded in larger socio-cultural, political and economic inequalities" (Standing et al. 3). Such claims are related to feminist arguments that attempt to complicate the narrative around women of color when it comes to reproductive and sexual health.

Within "Retrieving the Baby: Feminist Theory and Organic Bodies," Bev Thiele argues against completely rendering biology irrelevant in the conversation about reproduction and reproductive healthcare. Thiele says this would not fully take into consideration the entirety of female experiences. She attempts to suggest a feminist

perspective that rejects biological determinism while still validating embodied, biological experiences. Thiele, Kinser and Lewis all take note of biological determinism when discussing female subordination by health institutions. Thiele in particular questions how women's reproductive capabilities play into this by shaping female bodies as more troublesome and more difficult to handle (51). Within feminism, the fight against biological determinism has been theorized through the lens of social constructionism, which involves the acknowledgement of the body as a social construct. In other words, the body is a cultural entity produced by society, not nature. Thiele clarifies that, "in recent feminist theory on corporeality and embodiment, the body is a shell, a surface to be inscribed, a terrain to be mapped, a discursive fiction" (51). The theoretical inscribing and construction of the body eventually manifests in reality, as the way in which the female body is viewed determines the way it is physically handled. These constructions impact the standards of reproductive and sexual healthcare, warping them to submit to the ideologies of oppressive social systems.

There are multiples dualisms at play in reproductive dialogue. Thiele recognizes body versus self as one of these core dualisms that is reinforced by other hierarchical binaries such as culture versus nature and social versus biological. While Thiele's argument omits this, the addition of an intersectional lens links racist and classist binaries to the reproductive dialogue of certain women. Thiele explains, "the binary terms are hierarchically ordered and mutually exclusive and are frequently mobilized in the positioning of women as inferior and subordinate to men" (52). To understand the body through a series of dualisms is greatly limiting by rigidly constructing bodies through

socially biased definitions. Cultural attitudes around the body push forward a narrative of control, especially when inscribing binaries with a clear favored side.

The result is discussions around the female body that minimize or diminish female suffering, writing a narrative around female health that normalizes differences as something troublesome, and therefore a sign of inferiority. This narrative allows for the reduction of female agency, inscribing passivity on the female form (Thiele 53). The solution that Thiele suggests is firstly a critique of any sort of feminist thinking that attempts to equate men and women in healthcare, because such attempts ignore the remaining existence of biological difference as it relates to physical health. To embrace a gender binary that supports biological determinism and essentialism is different acknowledging the purpose of different types of healthcare delivery and institutions. Definitions of health have historically and continue to be primarily shaped around a standard, male body; the inclusion of feminist concepts in health discussions allows for variance when discussing what health means and how this is to be achieved for different kinds of bodies.

A holistic perspective of health recognizes where women's health, as it relates to the specifics of female sexual identity, branches from that of men's. Thiele rationalizes, "Refiguring biology as process departs from the notion that it is fixed and unchanging, and opens the way for a consideration, not only of pregnancy and labour, but also the commonplace minutia of bodily changes which we all experience…" (54). Feminism's push for the specificity of reproductive and sexual health therefore encourages a complete rethinking of how to incorporate gender in a non-oppressive fashion. To move away from

the patriarchal ideology of biological determinism changes the way we think about the rigidness of science, while additionally recognizing the capability of the body to resist cultural agenda in its construction (Thiele 55). Additionally, institutional notions of the body eventual move from the public to the private sphere by influencing individual notions of the body. When considering the notion of the public shaping the private sphere, preconceived, patriarchal ideas of gender and reproduction carry immense weight in the decision making process around reproductive health.

Much of Thiele's argument is for retheorizing the body, attempting to move away from feminist theories of embodiment that suggest the body is just a recipient of static scientific inscriptions, instead viewing the female body as setting "every-changing agendas which shape and are shaped by cultural acts/inscriptions" (56). To move beyond the inscription of biological determinism means challenging social constructionism through lived experiences that present undeniable truths. Thiele does not mean to entirely discredit existing reproductive healthcare built around scientific knowledge, but rather attempts to discredit culturally inscribed notions of reproductive healthcare that are linked to notion of gender biology as an attempt of patriarchal justification. This argument highlights the malleability of science and the perceptions of biology and health that directly shape healthcare institutions to social constructionism. If the social cannot be separated from the science, then it is time to retheorize the social.

The most important takeaway from Thiele's theoretical work is this concept of retheorizing the physical body, acknowledging the potential of negotiation between body and self to disrupt social inscriptions. Thiele's argument lacks in its scope of the female

experience of reproductive health, overgeneralizing the female experience while simultaneously centering hers. Her thought of retheorizing the body in order to change the way it is physically handled falls short when considering the various types of bodies that exist and how the process of socially constructing them differs. No such intersectionality can be found in Thiele's theory, which holds a strict focus on the broad, heterosexual female experience of reproductive healthcare. Healthcare experiences differ radically due to race, ethnicity and class -- all additional factors of social inscription.

The concept of embodiment is not exclusive to the scholarship of feminism, as Rayna Rapp rationalizes within, "Gender, Body, Biomedicine: How Some Feminist Concerns Dragged Reproduction to the Center of Social Theory." However, it is feminists who developed a criticism of the politics of the body, identifying the physical body as a site of physical struggle. As Thiele explains it, the body is inscribed with cultural and political beliefs, as the theoretical manifests itself into physical handlings of the body. Such notions work against body/mind dichotomies, destroying the concept that "inner" and "outer" are independent entities (Rapp 467). Social structural analysis recognizes the role of gender politics in the medicalization of female bodies, a process almost overwhelmingly on controlling reproduction and sexuality.

A key concept that Rapp presents is stratified reproduction, which she explains as, "the hierarchical organization of reproductive health, fecundity, birth experiences, and child rearing that supports and rewards the maternity of some women, while despising or out-lawing the mother-work of others" (469). This concept links itself to the normalization and justification of discriminatory reproductive healthcare, as systems such

as race and ethnicity act in a hierarchical fashion, as does gender. The discrimination around reproduction can best be identified when recognizing what society wants to be reproduced. The social inscription of hierarchical ideologies frames different bodies reproductive and sexual capabilities differently. Stratified reproduction is found in the history of differential reproductive health treatment, allocating reproductive rights and justice through racial, ethnic, classist, and hetero-sexist criteria. Rapp believes that all bodies bear marks of stratified reproducers, with "discrimination etched into embodiment" (472). Another way to phrase this marking that Rapp describes is the process of othering, observing how this process changes from body to body. Rapp's analysis leaves room to put into conversation with Latina feminism in order to identify the workings of this process with Latinas in the context of the United States and their reproductive healthcare.

It is a difficult task to assign a concrete definition to either sexuality or sexual health as both concepts prove to be continuously in flux, not solely based on biological functions. Instead, within these concepts emotional and social aspects are also incorporated. The result is expansive notions of what good health is and looks like, leaving these concepts vulnerable to negative ideological manipulation. Within "Examining Sexual Health Discourses in a Racial/Ethnic Context," Linwood J. Lewis explains that the attempt to definitively define sexual health, as it relates to reproductive health, is complicated when considering the role that race/ethnicity plays in shaping those definitions and resulting policies. He argues:

> One single, umbrella definition of sexual health free from sociocultural, historical, and personal contexts is probably impossible, given the tension in definition of its

> root concepts of sexuality and health. The ideal of a single, natural, and normal sexuality and sexual health as the achievement of this essential sexuality is called into question by considerable evidence of variation in sexual behavior and its meaning across cultures, historical time, and over the lifespan" (224).

Lewis identifies two dominant forms of sexual health discourse in which race/ethnicity play a definitive role: preventative sexual health and eudaemonic sexual health. While sexual health is not synonymous with reproductive health, there is considerable overlap between the two influencing in the beliefs and practices that ultimately contribute to reproductive healthcare.

Race and ethnicity act as central organizing tools in both of the sexual health discourses that Lewis pinpoints, primarily as risk factors for disparities, but play out differently. The logic of the inclusion of race and ethnicity in this context greatly mirrors the concept of social determinants of health utilized by organizations when discussing health. The hyper focus on race/ethnicity that Linwood describes is a perspective that attempts to explain disparities in reproductive and sexual health more so through culture, rather than acknowledge discriminatory social and political causes (Lewis 226). The result is a skewed perspective of race and ethnicity as it relates to sexuality and reproduction, creating an association between bodies of a particular background and negative sexual behavior associated with health risks, societal harm, or both. This greatly homogenizes persons based on race and ethnicity, allowing for the support of harmful stereotypes revolving around sexuality and reproduction to be continuously supported and reproduced, influencing institutions within the public sphere and individuals in the private sphere.

Reproductive Agency and Autonomy

The legislation and narrative of reproductive healthcare is symptomatic of the utilization of gender as a tool of control. This gendered control adheres to a different agenda when combined with racial and ethnic specificity. The attack on women's reproductive choice belongs not only to issues of sterilization, also being highly debated in discussions of similar topics such as abortion. Existing parallels between sterilization and abortion present a definition of reproductive agency that does not readily appear in discussions of sterilization alone. Rosalind Pollack Petchesky's *Abortion and Woman's Choice* explores the concept of reproductive agency through her defense of abortion. Her argument frames abortion as the epitomization of individual women's agency when attempting to control fertility, therefore controlling the consequences of heterosexual sex (IX). This particular presentation of reproductive agency reallocates power from the public to the private, bestowing it upon the individual woman to determine her reproductive life. While this definition arises in defense of abortion, it is still able to applicable to the issue of consented and unconsented sterilization and questioning choices around the physical body.

Petchesky's exploration of agency in reproductive healthcare creates a necessary significant challenge to the dichotomy of decision making traditionally associated with reproductive health procedures. She argues:

> There are no individual solutions to the dilemmas posed by reproductive politics because '"choices" are not merely the product of self-motivated desires but depend on conditions existing in the society. The ultimate dilemma for those who seek to enhance reproductive and sexual freedom is how to create a sense of collective purpose--of feminist and social solutions---concerning matters that seem so intrinsically personal and private (388).

Similar to Thiele, Petchesky challenges the overly broad notions of reproductive health discourse by recognizing the link between private and public spheres. Agency, the capacity for an individual to freely act for themselves, is restricted in issues of reproduction by gender, race, ethnicity and more, defined by Petchesky as conditions. Autonomy additionally requires redefinition in reference to social justice in order to be applicable to the realities of all women (Petchesky XXV). The enhancement of free reproductive agency is to understand how these conditions permeate all spheres of life, inscribing themselves not only theoretically but physically, controlling the very notion of choice in explicit and subtle ways. Petchesky rejects the dichotomy of choice supported by classical liberalism that separates individual autonomy and social interdependence (395). The divide between these two is bridged by agency. Agency, as capacity, is influenced not only by individual choice but issues of access, power, knowledge, economics, etc. An assessment of agency requires an evaluation of social interdependence, while autonomy is a more abstract and private right.

Petchesky utilizes the term reproductive autonomy more than reproductive agency, arguing:

> In particular, will women not still retain a preemptive claim to reproductive autonomy...based on the principle of 'control over one's body'? Even in the context of revolutionary social relations of reproduction, it will never be legitimate to compel a person to have sex or to bear a child, to have an abortion or be sterilized, to express or repress sexuality in some prescribed way, or to undergo surgical or chemical or other bodily intervention for reproductive or contraceptive purposes (400).

In her defense of reproductive autonomy, Petchesky is simultaneously defining it, confronting the errors of exerting control over women's bodies through reproductive and

sexual control. Agency cannot exist without autonomy, especially when women have their reproductive choices regulated by social and institutional means. If legislation and policies do not already exist to regulate reproduction and decisions around the physical female body, then social regulation exists that too polices through negative social construction. Complex socialization surrounding reproduction manipulate notions of reproductive agency and autonomy, shifting priority away from individual women.

The Blindspots of Feminist Medical Ethics

Both feminist theory and medical ethics theory address concepts such as agency and autonomy and other related concepts, even if vocabulary slightly varies between the disciplines. Existing feminist literature discussing autonomy differs from the discussion of autonomy in medical ethics theory, which delves into notions of capacity and ability to act autonomously, in conjunction with its other principles. For instance, it is difficult to simply discuss autonomy without also involving other principles of medical ethics, especially when attempting to discuss a specific situation such as Latina sterilization. The discourse around reproductive rights heavily deals with female agency and bodily autonomy as a means of articulating a woman's right to make decisions revolving around her body.

Sterilization abuse is a clear violation of medical ethics, violating its four main principles – autonomy[5], nonmaleficence[6], beneficence[7] and justice[8]. These violations are

[5] The principle of personal autonomy is defined as an individual having, "self-rule that is free from both controlling interference by others and limitations that prevent meaningful choice, such as inadequate understanding" (Beauchamp and Childress 101). All theories of autonomy view liberty and agency as necessary conditions.

more easily identified in explicit acts of reproductive control and non-consent. Naturalized, subtle coercion, as is suggested by high rate of sterilization amongst Latina/Hispanic women in the United States, are less obvious violations -- but still violations all the same. While all four of these core principles can be applied to the issue of discriminatory reproductive healthcare and sterilization, certain concepts within medical ethics are more relational than others. One such concept includes relational autonomy, which is defined as an attempt to affirm autonomy by interpreting it through relationships. Prominent scholars within the discipline of medical ethics such as Tom L. Beauchamp and James F. Childress claim that this conception, is motivated by the conviction that persons' identities are shaped through social interactions and complex intersecting social determinants, such as race, class, and gender, ethnicity and authority structures" (106). While within medical ethics there is increased awareness of the root of health disparities, as indicated by literature around concepts such as social determinants of health, theory falls short in its application or analysis of real life experiences. Autonomy is acknowledged to be restricted by oppressive systems such as race, class, and gender, but the acknowledgement moves no further. Relational autonomy is a necessary theoretical concept at play when discussing Latina sterilization and questions of medical malpractice and abuse when utilized with a precise, intersectional lens.

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[6] The principle of nonmaleficence argues to never cause harm to others. This principle bears heavy resemblance to the principle of beneficence and must be continuously separated from it (Beauchamp and Childress 150).

[7] The principle of beneficence refers to the moral obligation to act in a manner that benefits others (Beauchamp and Childress 202). Beneficence differs from nonmaleficence because it involves not only preventing harm, but also removing that harm and promoting good.

[8] The principle of justice refers to, "fair, equitable, and appropriate distribution of benefits and burdens determined by norms that structure the terms of social cooperation" (Beauchamp and Childress 250).

Questions of coercion place heavier emphasis on agency in terms of the capacity that a Latina patient feels she has to make her own reproductive decisions. These decisions are manipulated and therefore restricted by the disparities reinforced by race, ethnicity, gender, etc.

Additionally Beauchamp and Childress link autonomy and competence together, two concepts that make up the bulk of the sterilization narrative. They state, "although autonomy and competence differ in meaning (competence meaning the ability to perform a task or range of tasks), the criteria of the autonomous person and of the competent person are strikingly similar" (116). The agency to claim autonomy or prove competency are ultimately hindered by racism and sexism within reproductive healthcare. For instance, the history of Latina reproductive healthcare brings into question definitions of competence. For instance, eugenics based reproductive healthcare has been justified because of the social construction of brown bodies as less than human, therefore being less capable of making "proper" healthcare decisions. Brown bodies, such as Latinos/as, are socially constructed to be reliant on dominant (read: white) society for judgments and decision-making, as Anzaldua's Borderlands reminds us. The criteria of competence are therefore skewed and shaped by industrial complexes shaped by systems of inequality. Negative constructions of the Latina body allow for race, ethnicity and class, in conjunction with gender, to negatively warp criteria of ethical medical treatment such as competence, to devalue, "other" and ultimately harm Latinas. This is best exemplified through examination of sterilization acting as a vehicle for this dangerous rhetoric.

Feminist approaches to medical ethics argue for a rethinking of current structures in place that act as guidelines for healthcare. The intersection of medical ethics and feminist theory emerges through the concept of the ethics of care, originally introduced by Carol Gilligan (Beauchamp and Childress 35). This model identifies two dominant modes of moral thinking within healthcare: ethics of care and ethics of rights and justice. The ethics of care refers to care that centers itself on the connection between needs, care and prevention of harm. In contact, ethics of justice incorporates more impartial principles that removes itself from what cannot easily be deemed objective and therefore rational.

Carol Gilligan's model of the ethics of care has a broad intended female demographic. Gilligan's theory lacks racial or ethnic specificity, taking into consideration only the differences between men and women with regards to care, but not the differences among women. Her theory needs to be added to in order to eventually clarify the issue of reproductive healthcare for Latinas through the application of Latina feminist thought. The discourse of Latina feminism allows for the development of specific strategies of care, dehomogenizing the female experience by validating the notion that not all women define their health in the same manner.

Gilligan's theory of care ethics is fundamentally flawed in its essentialist nature and has been continuously revised and expanded upon. Within "Rethinking Care Ethics: on the Promise and Potential of an Intersectional Analysis," author Lena Hankivsky takes the first steps to joining different theoretical disciplines in order to facilitate a necessary

shift in thinking around medical ethics. Hankivsky emphasizes the missing intersectional component of this theory, explaining:

> In particular, the article demonstrates that evaluated against intersectionality perspective, even the most nuanced, complex versions of care theory fall short because they center and prioritize gender and gendered manifestations of power. As a result, when care scholars consider factors beyond gender, they are inclined to *add* race and class rather than consider the ways in which these are co-constructed in multiple ways and with various effects (252).

The error of primarily focusing on gender is that any kind of analysis is limited from the start, risking loss of efficiency in achieving the goal of bettering women's reproductive experiences or making claims to dismantle social constructionism. In this case, primarily women of color are being affected. There is value in care ethics' relationship base that emphasizes human interdependency, but these relationships that care ethics promotes is only unproblematic when recognizing differences in experience. However, this paradigm is fluid in its recognition of intersections of identity construction.

The notion of care within healthcare is continuously negotiated when intersectionality and care ethics are combined in order to keep power relations in balance (Hankivsky 259). Combining medical ethics with feminist concepts from women of color enhances strategies to address the reproductive concerns of Latina, whose experiences can only truly be addressed through an intersectional approach. Scholars such as Hankivsky provide a blueprint that justifies the application of intersectional care ethics to reproductive healthcare. The link between care ethics and reproductive healthcare is most easily made through the shared component of human relations between the two. Care ethics is both a moral and political concept (Hankivsky 253) that prioritizes the

prevention of human harm and suffering, which compliments the human rights based goal of a reproductive justice agenda.

Incorporating Hankivsky's interpretation of care ethics in reproductive healthcare therefore makes a lack of intersectionality an ethical violation. Specificity justified by intersectional thinking differs considerably from discriminatory healthcare in its intent to dissolve disparities rather than reinforce them to support a problematic socio-political agenda. If a model of care ethics is used, basing itself in interpersonal relationships, without intersectionality, relationships of power and domination are fostered (Hankivsky 254). Additionally, biological determinism often undergirds the application of care ethics. Such can be observed in the continued occurrence of inadequate and sometimes abusive reproductive healthcare for women such as Latinas, as race and ethnicity are being utilized not as tools of understanding, but tools of othering and domination. Hankivsky further explains, "where intersectionality is distinct from care ethics is that it requires reflexivity and reflection on producing knowledge, precisely because knowledge production is laced with power" (259). The fluidity of intersectionality may be difficult to translate into policy, but intersectionality based healthcare gives attention to those in marginalized social locations that have been largely ignored.

Women of Color and Reproductive Justice: Establishing Latina Reproductive Discourse Around Sterilization

The discussion of Latina reproductive healthcare takes from the conversations of both the mainstream reproductive rights movement and the reproductive justice movement. In "Teaching About Reproduction, Politics and Social Justice," Kimala Price

distinguishes between the discussions of the two movements in order to lay down the theoretical foundations of the politics of reproduction. Reproductive justice distances itself from reproductive rights by centralizing its focus on social justice and international human rights doctrines rather than individual rights (Price 43). The framework of reproductive justice is an intersectional one, as it draws links to various socioeconomic factors that are omitted in the conversations of mainstream feminism and the mainstream reproductive rights movement. In the discussion of Latina bodies and reproductive healthcare, the concept of reproductive justice is more applicable for its goal to "transform political, social, and economic institutions…organizing within traditionally marginalized communities" (45). This ideology is compatible with the core concepts of Latina feminist theory that come to the surface when evaluating the social construction and physical treatment of Latina bodies.

Price cites Kimberle Crenshaw's theory of intersectionality as one of the core piece of reproductive justice's theoretical foundation. The discourse of the reproductive justice movement begins to move where feminist medical ethics has not, pushing for the reconsideration of the barriers for certain individuals to access their human rights to health and bodily agency. Latina feminist thought has theorized around reproductive rights and justice, but there still lacks a cohesive synthesis of foundational texts such as the Borderlands theory with the agency of the physical body as it relates to the experiences of Latinas within the United States. The Latina voice remains unrepresented within medical ethics, as existing feminist theory addressing medical institutions continue to overly homogenize the struggles of women of color, failing to expand the full scope of

intersectionality. Latino activist groups such as the Brown Berets and the Young Lords have historically tried to give attention to the reproductive rights of Latinas, but not to the scope being suggested within this project.

The agenda of the reproductive justice movement rose as a response to the failures of the reproductive rights movement to include the reproductive experiences of women of color. The incorporation of these experiences worked to theorize for them in order to contribute to the overall narrative of female oppression. Reproductive justice incorporates what reproductive rights does not when it comes to discussing healthcare: race, class, gender and immigration experiences of different groups (Silliman et al. 6). To answer the question that this project poses, the theoretical framework established within this section can be used to retheorize the reproductive history of Latinas in relation to sterilization. This process of going through the history of Mexican and Puerto Rican women in the United States generates alternative or extend definitions of autonomy, agency and reproductive justice.

CHAPTER TWO: INTERSECTIONALITY AND LATINA REPRODUCTION

The next step in identifying the ways sterilization has shaped reproductive healthcare is to take the theoretical framework developed in the previous section and utilize that perspective to work through a miniscule portion of the reproductive history of Latinas within the United States. This chapter takes the framing of Latina experiences that theorists such as Anzaldua present in the Borderlands theory and puts it into context, expanding upon the construction of Latinas and their reproducing bodies in the United States. For instance, there is more to be discussed with regards the issue of Latina identity

that Anzaldua's theory alone goes into. Introducing feminist intersectionality first, alongside the Borderlands theory, frames the way in which Latina identity is understood as it relates to the social perception of Latina bodies. Going through the timeline of Latina reproductive history with the theory in mind puts the central process of retheorizing Latina bodies into action. The construction of Latina as both a race and ethnicity impacts the gendering of Latinas in a manner in which is reflected within reproductive health. This chapter seeks to explore the Latina reproductive figure using the theoretical framework developed using scholars within the disciples of feminist theory and medical ethics. By working through the examples of sterilization abuse in the reproductive history of Latinas within the United States, theory is put into action to attempt defining Latina reproductive agency.

Within this project, the concept of Latina reproductive agency is based on the histories of women of Mexican and Puerto Rican descent. There is a link between the reproductive experiences of Mexican and Puerto Rican women because these women that all fit under the Latina label and have received similar treatment, despite being of different ethnicities. The cases of sterilization legislation in Puerto Rico, coerced sterilization abuse of Mexican women and contemporary Latina sterilization rates all represent separate but related instances of failures of reproductive healthcare institutions to move beyond harmful social constructions of Latina women. Reduced agency and autonomy were available for these women when constrained by persistent and restrictive social beliefs that are normalized and therefore incorporated in structures such as

healthcare. The limitations and failures of the healthcare systems in maintaining the rights of Latinas are exemplified through these histories.

Rather than entirely retrace the relationships between Puerto Rico, Mexico and the United States, this chapter analyzes isolated events in history relating to Latina health experiences to highlight trends revolving around gender, ethnicity, and race. Scholars Lorena Gutiérrez and Iris Lopez both go into depth in their respective works covering Latina reproductive history, both presenting similar conclusions about the origins of opposition against Latina reproduction. Both Mexican and Puerto Rican populations have been historically deemed by the United States as struggling with overpopulation and poverty, with claims tightly linked to racial, ethnic, and gender assumptions (Vigen 22). Interactions between the United States and Latin American countries such as Puerto Rico and Mexico only begins to inform the function and process of constructing Latina bodies and its impact on reproductive healthcare.

Latina Identity Within The United States: Race Versus Ethnicity

The label Latina invokes conversations of both race and ethnicity within the context of the United States. The oversimplification of this identity is largely attributed to dominant US culture constructing this pseudo race through policy and institutional language. As explained by Amy Kaminsky in "Gender, Race, Raza," the term Hispanic within the United States derives itself from a history of colonization, imposed by dominant culture as a control strategy (9). The link between gender, race and ethnicity stems from their shared function of assigning notions of superiority or inferiority, reinforcing prejudiced power dynamics. These concepts derive their justification through

biological terms, naturalizing the categorization and separation of persons. Race, like gender, is inscribed on the body and argued, unchangeable.

While the labels Hispanic and Latina might be used interchangeably, through the course of this project only terms related to Latina will be used. Latina better refers to peoples of Latin American origin, rather than Hispanic that more so encompasses people of Spanish speaking countries. The history and theory presented within this project are linked exclusively with Latina identity, or some subgroup within that, such as Chicana. Additionally, the presentation of the Hispanic/Latino identity by dominant culture contrasts with that of Hispanic/Latino cultures that are not as rigid. Kaminsky presents the notion that, "as a cultural construction race is unstable and has different meanings and different purposes in different times and places and that gender is fundamental in making those meanings and revealing those purposes" (8). In other words, the destabilizing of race when it comes to the Hispanic/Latino is a way of recognizing the diversity of races within this particular ethnicity. A feminist critique of the function of race involves making parallels between the two processes as they work to create different types of bodies that receive different societal treatment.

Kaminsky argues that the theorizing of race within academic feminism is a challenge when considering the "instability of race itself and the part gender plays in naturalizing what gets called 'race' in and across cultures" (7). This theorizing process works to homogenize peoples by their shared identity and especially in the case of Hispanic/Latino. When feminist scholarship treats race as a stable category, variations of experience are erased and silenced. To destabilize race means to protect the

homogenization process through an awareness of the complex history of Latin American countries and the impact this has on the facets of identity construction. Otherwise, Kaminsky explains, feminists are partaking in a form of essentialism that limits women of color such as Latinas from generating an independent voice within the discourse or creating a discourse all their own. They are oppressed not only by gender, but race at the same time. The complementary nature of race and gender as tools of stigmatization and social control exemplify themselves in the societal fear of immigrant motherhood.

The complex history of Latin America, riddled with imperialism, colonialism and immigration, has resulted in countries with peoples of many races. There is no singular racial category associated with the Latino identity. That fact in itself makes it difficult to assign a singular race to a person of this particular ethnic background. This exemplifies the "stabilization of race as a function of nationality," glossing over racial hierarchies within those countries that emerged from colonization and imperialism (Kaminsky 17).

The institutional categorization of Latinas is a small part of the larger process of control through socio-political means. Reproductive control is a way of denying reproductive rights to women, while identity markers such as Latino, functioning as both race and ethnicity assist in identifying problem demographics. Put together, these strategies of marginalization not only construct a specific group as a problem, but attempt to solve the problem as well. Utilizing ethnicity to inscribe race alongside gender on the body works to ultimately generate a justification surrounding differential reproductive healthcare beliefs and practices that additionally involve processes such as dehumanization and commodification. These identity markers belong to the overall

othering process that feminists have identified, exclusively impacting women of color. The result is an environment that reduces personhood for individuals, allowing for moral and ethical violations to go unaddressed and unquestioned. Intersectionality uncovers this marginalization that reframes inherently violent and discriminatory practices as a necessary practice for the advancement of societies. The symbolic justification of denying reproductive rights/justice is achieved through the negative and homogenizing social construction of Latina bodies, inscribing characteristics such as destructive and dirty upon the "foreign" female body.

This homogenizing, social construction of the Latina body is a shared experience among the many Latin groups within the United States. While peoples from each country in Latin America are present within the US in some way, some of the most dominant groups within the colonial United States are Latinas with origins from Mexico and Puerto Rico. Both of these countries have had long and complicated histories entangled with the United States. Parts of Mexico, for instance, are now parts of Texas, California, etc., and some would argue that one of the first languages in the United States was Spanish, thanks to early Spanish settlers. As a current commonwealth of the United States, Puerto Rico finds itself an odd limbo of outsider and object. The historical experience of women of both Mexican and Puerto Rican origin serve as foundational evidence of the harmful reproductive healthcare practices informed by negative perceptions of certain races and ethnicities. While the violation of reproductive rights can be applied to a number of instances, Mexican and Puerto Rican women in particular have a shared history of sterilization abuse, presenting viable case studies.

Exploring instances of sterilization abuse serves as a case study to understand the violent and harmful framework of reproductive healthcare created by uninterrogated racist and sexist practices. In isolation, the procedure of sterilization is a method of permanent birth control. The procedure gains meaning and social significance when utilized as a tool of gendered and racialized ideological agendas. On a micro level, perhaps a woman has decided that she does not want to risk pregnancy and never wants to have children, or already has children and does not want anymore? Perhaps there is a dangerous health concern affiliated with pregnancy and sterilization permanently neutralizes that threat? All these decisions are ethical, autonomous ones. However, these potential motivations for Latinas are warped and misused in instances of sterilization abuse and blatant reproductive control. Gender roles already greatly influence decisions around motherhood and sexual behavior, but this female vulnerability is only heightened with the addition of race and ethnicity.

The discriminatory use of race and ethnicity in reproductive discourse generates a framework for motherhood and sexual behavior that clearly indicates what kind of background is desirable for becoming a mother. Motherhood and sexuality are restricted in healthcare practices by using race and ethnicity as markers of undesirability, tagging certain bodies as not only unwanted, but also as undesirable reproducers. This notion helps to justify medical malpractice by framing certain women as deserving of it[9]. This ideology inserts itself into medical discourse and ideology, skewing ethical reproductive

[9] Conceptions of motherhood and sexuality vary by culture for Latinos, usually reliant on gender and religion. They play out differently in the United States as race and Western notions of gender influence reproductive and sexual experiences of Latinas, especially in conjunction with Western assimilation and xenophobia (Garcia 2012).

healthcare to rather serve fabricated notions of societal benefit. Using race, ethnicity and gender as markers for bodies requiring external control contributes to the justification of utilizing reproductive health procedures as a tool of a larger discriminatory agenda.

Sterilization as birth control was legalized in Puerto Rico in 1937 and in the United States in 1967. Prior to this legalization, voluntary birth control options for women was very limited, as the oral contraceptive pill was not yet in development in the 1930s, and not a popular option in the 1960s. The limited resources for birth control can only partially be attributed to lack of scientific development and more so to how legislation around birth control reflecting moral and ethical perceptions of birth control in each context. Sterilization abuse is a human rights violation, as it allows for interference, "with the fundamental individual right to decide, if, when, and how many children one will have" (Lopez XII). Prior to the legalization of sterilization as a form of birth control, forced sterilization occurred through legal means in addition to medical malpractice (Stetson 195). The marketing of sterilization as a birth control option masks the potential of coercion from external forces when making decisions of reproductive control. Legislation and policy shape the language used to discuss sterilization, creating these potential spaces for marginalization and violence to take place.

Puerto-Rican Women and Sterilization Abuse

Iris Lopez's work entitled, *Matters of Choice: Puerto Rican Women's Struggle for Reproductive Justice* is a central piece that presents the complex history of the relationship between the United States and Puerto Rico in regards to reproduction. Puerto Rican women have a history of poor experiences with both general medical care and

reproductive care, on and off the island (Lopez 128). The birth control pill movement in particular is exemplary of the previously mentioned sentiments towards Latina reproduction, relating itself directly to instances of sterilization abuse. For instance, women in Puerto Rico were used as experimental subjects for early clinical trials of birth control pills in 1956 (Lopez 17)[10]. Puerto Rican women were viewed as the perfect subjects in these trials due to beliefs of hyperfertility, overpopulation, and more (Lopez 15). The birth control movement within the United States garnered its support from various socio-political ideologies, some of the more dangerous being the joint action of eugenics and population control. Traces of this hateful rhetoric played itself out considerably in the relationship between Puerto Rico and the United States, beginning in the early 1900s. Population control policies framed women as the bearer as societal problems, believing that restricting their reproduction would result in societal betterment.

Sterilization was legalized as a form of birth control in Puerto Rico in 1937 (Nelson 122). However, support for sterilization as a means of population control was vocalized long before this legalization[11]. The popularity of sterilization among Puerto Rican women was matched by the support by the medical community as the procedure become the most heavily promoted method of contraception during the 1900s. There was a particular positive association made with sterilization in Puerto Rico, which Jennifer

[10] Amongst the American contraception researchers that implemented the birth control trials in Puerto Rico were Dr. Gregory Pincus, Hale H. Cool, Dr. Clarence J. Gamble and Adaline P. Satterthwaite, all working with Margaret Sanger. Beliefs about overpopulation and poverty threatening public health motivated the researchers to chose Puerto Rico as the location for their experiment (Nelson 124).

[11] In 1922, Luis Munoz Marin, was a public figure who vocalized his support for Margaret Sanger and her ideas around birth control. Nelson reports that, "He argued that the birth control ideas promoted by Margaret Sanger would save the island from becoming overrun with too many mouths to feed, too many children to clothe, and too few resources" (122).

Nelson delves into within *Women of Color and the Reproductive Rights Movement*. She explains, "For some women, the highly medicalized aspect of the sterilization procedure helped overcome the sense that birth control was immoral[12]. Many women also chose sterilization because they believed that other contraceptives were dangerous, dirty, only for use by prostitutes, or the cause of infidelity" (123). The socialization of Puerto Rican women around sterilization played directly into the dominant narrative produced by a society influenced by United States ideology. The accounts collected by scholars of Puerto Ricans exemplifies how the perceptions they had of their bodies was informed, in part, by external perceptions and beliefs about Latina bodies.

Concerns of overpopulation on the island lay the foundation for notions of Puerto Rican hyperfertility that played into the stereotype that Latinos cannot control their reproduction. These beliefs are believed to have influenced various policies concerning the United States and Puerto Rico. Lopez claims that, "in essence, migration was used as the temporary response to Puerto Rico's overpopulation problem, while sterilization became the permanent solution" (7). For instance, the granting of US citizenship to Puerto Ricans in 1917 arose at the same time of government policy around sterilization (Lopez 7). Puerto Rico's economy was developed through emigration and sterilization, through the policies of both the United States and Puerto Rico.

Widespread sterilization in Puerto Rico is believed to be symptomatic of this past of government-backed sterilization policy adhering to desires of population control and

[12] Notions of immorality and birth control emerge from cultural beliefs surrounding sexuality and womanhood, which varies from culture to culture for Latinos. These conceptions are often additionally linked to religion, tightly intertwined with dominant culture in Latin American countries.

birth control. The colonial relationship between Puerto Rico and the United States resulted in the intertwining of birth control and reproduction politics (Lopez 12). Clarence Gamble, the leader of the US eugenics movement, assisted in the implementation of full sterilization program in Puerto Rico in the 1940s (Silliman et al. 220). Essentially, a restrictive birth control market left sterilization as one of the only forms of birth control available to women. In "Puerto Rico: A Case Study of Population Control," Bonnie Mass identifies factor such as poor healthcare services and inaccessibility to safe abortion and IUDs (78). In the late 1930s alone, fifty-three clinics were opened through Puerto Rico that offered sterilization services, meant to control population growth (Mass 69). In the fifties, with the support of the United States government, 160 private birth control clinics and several small hospitals were opened by Puerto Rico and the commissioner of health that provided sterilization services (Mass 71). Additionally, evidence has been reported about mass sterilization performed in private hospitals and in clinics placed in low income areas during the seventies (Mass 76)[13]. Legislation around sterilization legalization and medical clinic development complemented agendas belonging to eugenics and population control, restricting reproductive agency and autonomy through limited opportunities related to reproductive healthcare.

Lopez illuminates that, "the policies of the United States and colonial governments were such that migration and sterilization were used as alternative and

[13] An investigation team from the United States visited Puerto Rico in 1975 and uncovered that ⅓ of Puerto Rican women of child-bearing age had been sterilized. These statistics parallel that in 1973 Puerto Rico had one of the lowest natural population increased in Latin America (Mass 71).

reinforcing mechanisms" (9). These policies reinforced certain notions within both the public and private sphere about reproduction and Latina bodies not based on fact, but pure prejudice. The symptomatic results from such policies primarily comes in the form of maintenance of the same oppressive systems that created them. This maintenance normalizes problematic reproductive healthcare practices and beliefs that pay no attention to the rights guaranteed under medical ethics that *should* be incorporated first and foremost. In this context, to opt for sterilization is not a woman exercising her reproductive autonomy nor agency; instead, deciding to be sterilized resulted due to the lack of alternative options.

An example of a policy that linked development and sterilization were government programs such as Operation Bootstrap in the 1950s. This program attempted to bring women into the workforce, but also encouraged them to become sterilized when doing so (Silliman et al. 220). Acting as an industrialization program, U.S. corporations were offered tax-free status if they operated on the island (Lopez 8). In this situation there was blatant coercion perpetrated by both the Puerto Rican and United States government, marking these Latina bodies as unable to contribute to a successful society unless their reproductive capabilities were kept under control. Giving women limited resources for reproductive healthcare that additionally complemented a discriminatory population control agenda was in no way a coincidence. However, Nelson notes that this policy failed to keep Puerto Ricans on the island and greatly influenced increase migration patterns to the United States (122), thus adding fuel to the fire of racist and xenophobic sentiments.

Programs such as this drew upon the vulnerabilities created by race, ethnicity and gender to completely seize control of the autonomous Latina body. Normalizing sterilization through a limited birth control market and socioeconomic incentives such as employment opportunities-- as it was amongst Puerto Rican women that became socialized to believe sterilization was the only effective birth control available to them -- assists in strengthening and maintaining the facade of choice, continuously masking dehumanization and the manipulation of medical ethics to support an oppressive agenda. The Latina body becomes the distinct battleground of political and social anxieties around race and ethnicity, her gender marking her as such.

The casual perception of sterilization amongst Puerto Rican women as a form of birth control is not isolated from the xenophobic, racist rhetoric of the United States towards Latinos[14]. This historical example of Puerto Rico is slightly more complicated than that of Mexican origin women because while this abuse did not occur within the United States, rather on a different country, the ideologies that motivated and justified the sterilization policies clearly seem to have originated within the United States. This colonial aspect speaks largely to the persistence of the social construction of Latina bodies as Others that require intervention and guidance in the form of restrictive legislation. Race, ethnicity and gender coincide here as they alter the standards of healthcare practice and beliefs indicate the centralization of societal fears of Puerto

[14] Bonnie Mass's 1977 study "Puerto Rico: A Case Study of Population Control" revealed increasing rates of sterilization in Puerto Rico between 1947 and 1968, moving from 6.6% to 35.3% (72). Additionally, surveys taken among married sterilized Puerto Rican women presented positive attitudes towards sterilization. 73.4% of sterilized Puerto Rican women, surveyed between 1920 and 1949 claimed they would chose sterilization, versus 26.6% who said they would not.

Ricans on the female body. Contemporary sterilization rates exemplify how the history between the United States and Puerto Rico on the island eventually carried themselves to the United States.

Mexican-Origin Women and Sterilization Abuse

Separate but similar to Puerto Rican sterilization is the forced sterilization that has taken place within the United States. Within *Fertile Matters*: *The Politics of Mexican-Origin Women's Reproduction*, Gutiérrez retraces the social science and demographic research involved in the analysis of Mexican-origin women's fertility that serves to reinforce certain negative stereotypes revolving around reproduction and sexuality. Gutiérrez's work heavily explores the normalization of race and ethnicity in cases of medical malpractice, as exemplified through discriminatory reproductive control. Gutiérrez uses the 1978 case *Madrigal vs. Quilligan* as a primary example of the negative social construction of Mexican women's bodies that resulted in the coerced sterilization of numerous patients. The case that Gutiérrez investigates assists in answering the question this project poses because of the implication of the actions of those involved with regards to control Latina reproduction as a response to the negative social construction of Latina bodies.

Madrigal vs Quilligan was filed in 1975 as a class-action civil rights suit in the federal district court of Los Angeles. USC-Los Angeles County Medical Center, along with twelve doctors, the State of California and the US Department of Health, Education, and Welfare were named as defendants, and ten Latina women who were sterilized without their consent as the plaintiffs. The women alleged that the medical staff of

LACMC coerced them into sterilization, with claims of lack of informed consent, with clear racial prejudice in their testimonies of treatment (Gutiérrez 44). Under the direction of Dr. Edward James Quilligan, the Women's Hospital of LACMC promoted birth control to female patients, which primarily consisted of sterilization and is interpreted as the hospital's response to high birthrates of their primarily minority clientele (Gutiérrez 43). Communication lacked between patients and the medical staff, due to language barriers differential levels of medical knowledge of reproduction and its associated procedures. Patients lay claims of lack of informed consent, having little to no understanding of what the process of sterilization meant. Various women had sterilization presented to them as a necessary medical procedure when it was not, or as a procedure that could be one day reversed, only to discover that the ability of having children had been lost. Gutiérrez explains:

> Not only do these incidents demonstrate the ways patriarchal, class-based, and racial ideas were used by hospital personnel to coerce Mexican-origin women into sterilization, they also show how ideological notions impact medical practices (44).

The specifics of the legal case of *Madrigal vs. Quilligan* and the treatment at LACMC illuminates a deeply rooted issued within medicine and reproductive healthcare that dangerously constructs bodies that are not only less than human, but incapable of responsible, autonomous thought. This construct increases Latina susceptibility and vulnerability to violence in the form of medical malpractice. In this specific situation alone, doctors made use of patients' racial/ethnic identity and immigrant status to coerce them into sterilization (Gutiérrez 44). The decision made by the medical staff involved them not only being informed by their socialized understanding of Latina bodies, but

maintaining this construction through the justification of their actions and the ideology supported through it. Mexican women had their bodies marked for their otherness, their ethnicity and race acting as a marker of difference that simultaneously implied incompetent reproductive responsibility. This perspective is reflective not only the actual act of sterilization abuse, but additionally in the response of the legal court to the sterilization of all ten women.

At LACMC, sterilization was presented as a necessary procedure by the medical staff rather than optional. The problematic nature of this situation raises questions of what is really necessary about certain medical procedures and what source's definition has greater weight. Latina women, which in this case were all women of Mexican-origin, were coerced into signed permission forms by the medical staff, either through misinformation about the procedure or threatening to withhold pain medication (Silman et al. 222). Additional tactics taken by the medical staff at LACMC included telling patients that sterilization was necessary for survival or that after a certain number of Cesarean sections California law required sterilization. Gutiérrez reports that the patients at LACMC "were not just subjected to single incident of coercion but were harassed continually by nurses and doctors" (42). The strategies that the LACMC staff utilized pre existing health disparities due to race, class and gender that left these Mexican-origin women in a position of vulnerability.

To use the language of medical ethics: perspective heavily informed by notions of race, ethnicity and gender allowed for the logic of medical professionals to justify the coercion of Latina patients as an act of nonmaleficence and beneficence to not only the

patient, but also society. Practices at LACMC were largely informed by public interpretation of birth rates as an indication of Latina hyperfertility and its correlation with related issues such as overpopulation and poverty (Gutiérrez 40). This particular center had mostly minority clientele, a demographic that they tried to serve by reducing their birth rates. Gutiérrez explains: "The physician's attitudes toward the LACMC clientele, and their perceptions of their own role in providing a panacea for overpopulation, were intricately linked" (43). The medical ethics intended to serve all persons and act as an extension of human rights are twisted in this situation. Sterilization functions to not only assist the patient in no longer burdening society, but additionally assist the patient from their own ignorance about their situation.

In court, the case was reduced to a case of cultural difference based on family structure and size (Gutiérrez 47). The judge, Jesse Curtis, juxtaposed Western culture's concern of overpopulation with Mexican culture's value of fertility, reinforcing associated notions of race, ethnicity, class and gender in his decision. All the doctors in the case were absolved of responsibility of coercive actions, because in most cases permission was given in some form. Gutiérrez explains that Judge Curtis, "stated that the doctors were entitled to invoke social motivations for actively encouraging sterilization as long as they had some medical rationale" (46). The ethical question of lack of informed consent was ignored through these legal procedures, as instead the actions of the staff at LACMC were framed through the lens of nonmaleficence and beneficence on a larger societal scale. The medical rationale that this case refers to justifies coerced sterilization as a means of saving these Mexican women from themselves, associating

societal problems such as poverty and overpopulation to the fault of the individual and therefore the responsibility of the institution to guide. While the doctors in this case may have been able to portray themselves as ben

The history of Latina reproductive control exemplifies a complete disregard of human rights and its associated medical ethics. This denial of rights – reproductive, human, ethical – is justified and made to work only by first constructing and inscribing the Latina body in a manner that effectively dehumanizes and vilifies. Xenophobic arguments of overpopulation, job decrease, misperceptions of Latino culture, etc., all play a role in the utilization of race, ethnicity and gender as central parts of a larger system of control (Gutiérrez 4). Additionally, xenophobia is very much parallel to colonist ideology that originally set the foundation for these particular social constructions of Latina bodies as contagions that require control (Gutiérrez 5). As inscriptions of exotic and terrifying qualities benefited the logic of the colonizer, the same logic continues to benefit a society attempting to maintain certain power hierarchies that thrive off of the marginalization of certain types of bodies. This marginalization and control is only achievable by denying Latinas reproductive agency and autonomy, completely limiting the capability of independent and non coercive choice.

In this situation, the quality of life of Latinas is only considered in relation to larger society, or attempting to minimize the burden Latinas bear on American society. In other words: "The individual experiences of the women involved in the Madrigal trial suggest a range of manipulations of power and privilege that coalesced at LACMC to rob women of Mexican origin of their reproductive liberty" (Gutiérrez 44). This

discrimination is not the kind of attention Latinas require when it comes to reproductive healthcare – to rework race, class and gender to eventually create positive/beneficial attention for Latinas requires taking concepts from the feminism of women of color and Latinas specifically. Gutierrez's work takes into consideration the factors involved with Latina reproductive healthcare on both a micro and macro level. On a micro level, this includes reproductive behaviors and practices. On a macro level, this concerns political climate and its involvement in reproductive healthcare processes. On both levels, Gutiérrez argues that there is an undeniable link between ideological constructs and structural and institutional modes of reproduction and racial control (8). Racialized images and ideologies of reproduction are essential to the process of controlling reproductive choices of Latinas in order to naturalize sociopolitical beliefs amongst medical practices and beliefs. The discourse surrounding the specific situation of Mexican-origin women exemplifies how the utilization of race and ethnicity appeals to reproductive control as a means of nationalism and protection on macro and micro levels.

The atmosphere of *Madrigal vs Quilligan* on a macro level was largely characterized by remainders of the Americanization movement of the early twentieth century that targeted outsiders' reproduction as a symbolic reproduction of social problems (Gutiérrez 11). This historical public discourse around Mexican-Americans is largely representative of public discourse around Latinos as a whole, past and present. The racialized commentary of population control has underlying white supremacist ideology (Gutiérrez 15). Such was best exemplified through the development of the birth control pill and its linkage to population control attempts. Gutiérrez states, "While

overlapping in content to some extent, the population control platform was, in fact, in direct opposition to the reproductive rights platform" (29). Concerns of overpopulation and its associated issues, such as resource depletion, characterized the political atmosphere that established and maintained a social construction of Latina bodies that justified unjust reproductive control. Using political and legislative history that targeted groups such as Mexican-origin women, Gutiérrez argues that this context is the source of the social beliefs that are inscribed in the perception of reproductive behaviors and practices. These behaviors and practices developed alongside the construction of Latina bodies, with racial and ethnic beliefs bridging the two together to properly ensure a mechanism of reproductive control.

Historical and Contemporary Sterilization Rates

Lopez's research has found that in New York City alone, Puerto Rican women have a sterilization rate seven times greater than white women, a consistent trend since the 70s (XI). Her own surveys of Puerto Women in New York in 2008 attests that high rates of sterilization and hysterectomies reflect the inequities of the lives of Puerto Rican women, which includes factors such as gender subordination, cultural beliefs and medical disparities and inequities. Similar to Gutiérrez's work, although Lopez's research very specially focuses on Puerto Rican women, her conclusions can be applied to a more general discussion of the reproductive experiences of Latinas within the United States. Additionally, Lopez questions the nature of agency for Latinas when making choices related to reproductive health. The women that Lopez interviewed for her research expressed the rationale behind their decisions to opt for sterilization, in contrast with

instances of sterilization abuse in which the patient is sterilized without consent[15]. Lopez states, "However, even though she is making a decision, neither can one say she is demonstrating full reproductive freedom" (XII). This statement suggests that social influence is more likely than not involved in these types of reproductive decisions for women whose lives are heavily shaped by race and ethnicity.

The speculation of true autonomy and agency with regards to Latinas voluntarily opting for sterilization is not a notion unique to Lopez. In the early 70s the Young Lords Party, a nationalist Puerto Rican group within the United States with a reproductive rights agenda, also questioned true nature of choice for Latinas opting for sterilization. Suspicious of the high sterilization rates in areas like New York, perceiving them as indicators of international population control of undesirable persons (Nelson 126). Nelson explains these early suspicions, stating:

> Social biases discourage many women from choosing nonpermanent methods of fertility control, such as a diaphragm or condoms, the pill caused unpleasant side effects (including death), and female sterilization was more available than any of the nonpermanent methods. Under these circumstances, Puerto Rican women had no real choice about birth control (126).

Nelson alludes to existing health disparities resulting due to socioeconomic differences that dramatically impact healthcare access and qualities. This stance that the Young Lords Party took regarding Puerto Rican women in the United States and their reproductive lives carries into present day observations, as rates continue to demonstrate these same trends. The restrictive circumstances to which Nelson refers to include

[15] Lopez reports that half of the women she interviewed reported that they would get sterilized again, while the other half would not due to regret. Additionally Lopez reports that, "many of the women who said they would get sterilized again qualified their response by saying that if their life conditions improved they would not seek the procedure" (127).

structural inequalities perpetrated by race, ethnicity and gender that are reflected in measurable healthcare disparities. This refers not only to equal access to various forms of birth control despite socioeconomic status, but the quality of healthcare delivery. For instance, how the dynamic between healthcare professionals and Latinas is heavily shaped by racial and ethnic stereotypes.

Statistics imply the prevalence of misinformation amongst Latina women regarding their sexual health, high rates of procedures such as hysterectomies and cesareans suggest that there is minimal attempt to educate these women[16]. Lack of knowledge establishes a power dynamic that takes away agency from Latinas, violates their ethical and human rights, no longer rendering them the beneficiaries of any healthcare procedure performed on them. Many of the women that Lopez interviewed for her 2008 study reported minimal education about reproductive options and sterilization technology (128). Procedures such as sterilization or hysterectomies play into a dominant narrative of controlling Latinas bodies/reproduction. These experiences, in addition to negative birthing experiences, vary depending on generation. For instance, the experience of a first or second generation Latina woman differs considerably from a third generation Latina, who perhaps has learned from the experiences of the women before her (Lopez 138).

[16] A study done by Karina M. Shreffler, Julia McQuillan, Arthur L. Greil and David R. Johnson in 2015 took data from the National Survey of Fertility Barriers to analyze sterilization by variables such as race, class and reasoning. Their study found that 31.69% of Hispanic women were surgically sterilized, and 40.68% of those women felt sterilization regret. This rate, though lower than that of Native American and Black women, was higher than that of Asian and White women (Shreffler et al. 38).

Some noted racial and economic disparities in healthcare include inconsistency of care, rushed visits and large patient-to-doctor ratios (Lopez 130). The results of such conditions are both poor quality of healthcare and poor doctor-patient relations. This situation very broadly refers to general healthcare, but these same issues also apply to the specifics of reproductive healthcare. Lopez further explains: "Institutional constraints, medical providers' negative ethnic and racial stereotypes, and sexism not only preclude poor women of color from receiving certain treatments for their general health care but also limit their reproductive freedom by influencing the kinds of recommendations they receive about reproductive surgery" (135). While directly alluding to the history of medical abuse that Latinas have received, these same sentiments carry themselves in the salient construction of Latinas as some requiring control, therefore upholding biased beliefs within medical institutions that ultimately impact practice. Free and untainted choice is never really an option for Latinas, who have not only history weighing down on how they are perceived and perceive themselves, but contemporary manifestations of that inherently shaping all aspects of their healthcare.

For women of color to voluntarily opt for sterilization, such as Latinas who have particular stereotypes associated with their reproductive and sexual being, requires an in depth assessment of potential underlying influence in decisions that comply or compliment dominant discourse. Economic standing becomes one of those factors, as the right to bear children is questioned and ultimately denied when tied to a certain economic background. A 2013 study done by Ophra Leyser-Whalen and Abbey B. Berenson entitled, "Control and Constraint for Low-Income Women Choosing Outpatient

Sterilization" dictates how many Latinas associated their decision for sterilization as a way of providing a better life for themselves and children. Their study states:

> Again, these women were active agents in decisions on a birth control method that would suit both their lifestyle and their body. They were, however, constrained by larger economic systems as well as the health system, which was focused more heavily on women's bodies for sites of reproductive technologies (1120).

The racialization of class status and its intersection with gender all impact the reproductive agency and autonomy available for Latinas within Western society -- a difficult barrier to gauge without an intersectional perspective. The contraception decision making process is perceived to differ for women of different backgrounds, as their lives constructed differently and therefore the factors they have to consider are also different. The statistics compiled by Leyser-Whalen and Berenson, by the CDC and NCHS (Jones et al. 2012; Daniels et al. 2014) and by many others (Shreffler et al. 2015) reflect this, especially when comparing variable such as socioeconomic status and racial/ethnic background.

Lopez rejects the notion that, "Puerto Rican women are either voluntary agents or powerless victims…neither of these polar extremes presents an integral picture of most poor women's reproductive experiences" (XVII). She does not suggest that these types of decisions are conscious ones, but perhaps a perspective not considered as often when examining the capabilities of Latinas' reproductive agency. The subtle, coercible nature of discriminatory agendas -- which incorporate race, ethnicity, and gender – allow for them to be seamlessly embedded in institutions that should, in theory, be objective, such as medicine. This approach complicates the binary framework of reproductive choices for women of color such as Latinas by forging a new perspective that extensively breaks

down notions of race, ethnicity, and gender. This approach accommodates differences in experience by avoiding oversimplification, therefore complying with the requirements of an intersectional perspective.

Like Gutiérrez, Lopez develops the sociopolitical context around perceptions of Puerto Rican women's reproduction. She states, "Birth control developed to meet women's needs to space births and/ or prevent pregnancy. On the other hand, when birth control is designed to meet the requirements of the state, then it is population control" (XIII). This distinction that Lopez feels is important to make relates itself to her constant questioning of the true nature of Latinas' reproductive agency and how society inscribes certain agendas into medical procedures and institutions.

Jael Silliman and others explain in *Undivided Rights: Women of Color Organize for Reproductive Justice* the following: "For women of color, resisting population control while simultaneously claiming their right to bodily self-determination, including the right to contraception and abortion or the right to have children, is at the heart of their struggle for reproductive control" (7). Race and ethnicity are twisted to be justification of alienation and dehumanizing rhetoric, embodied and disguised in the name of medicine as both necessary and natural in the issue of reproductive control and sterilization. Sterilization is embedded with meaning as it is changed from a neutral medical procedure to a vehicle of a hateful agenda embedded in oppressing due to race, ethnicity and gender. To be punished for being an other by Anglo standards means to be interpreted as not capable of competent decision making, and therefore have agency and autonomy

entirely taken away through coercion, or are presented the facade of choice that build upon those same processes.

The Othering Process at Work in Sterilization Abuse and Sterilization Decisions

The reproductive histories of both Mexican and Puerto Rican women in relation to the United States are incredibly indicative of how social stigmas related to race, ethnicity and gender is inscribed on the body in a physical manner. Sterilization in particular is a harsh and definitive decision on who is able to bear children. While this is not to say that every woman who opts for sterilization has been coerced to do, differences in how lives are shaped and marginalization as a general process is felt makes a considerable impact on female notions of choice, agency and autonomy. Not all women are presented with the same influence-free environment to make these decisions. Reproductive decision making spaces are not impermeable to systems of social oppression such as race and gender, evidencing another case of the public versus the private, with the public clearly shaping the private.

The reproductive justice agenda seeks to question matters of choice, complicating its paradigm through a stronger argument about the nature of coercion. Coercion is the beast that blinds and binds reproductive agency and autonomy, coming in the form of structural, institutional boundaries. To assume that coercion is separate from matters of choice places emphasis on the individual, rather than recognizing the role that dominant society plays in these so called private spaces to shape or entirely take away the rights of the individual. Crenshaw's theory of intersectionality urges us to recognize when the individual cannot be held accountable for the marginal location in which hierarchical

society places them. This marginalization and ultimate dehumanization becomes internalized. Silliman expands upon this thought, explaining that prominence on individual choice, "obscures the social context in which individuals make choices, and discounts the ways in which the state regulates populations, disciplines individual bodies and exercises control over sexuality, gender, and reproduction" (x). Petchesky's questions of agency additionally compliments the notion of tainted decision making processes when arguing about the true complexity of the conflict around female reproduction. Again, the intent is not to invalidate decisions of sterilization, but rather to understand them better through an intersectional perspective that has a strong framework in both Latina feminist thought and medical ethics. History characterizes this context, giving clear indication of the roots of the negative social construction of Latinas. Only through the knowledge of this history can the contemporary manifestation of the harmful ideologies that construction Latina bodies be recognized to be addressed and reworked.

If the struggle is internal, as Anzaldua's Borderlands argues (109), then it is a result of marginalized and invisible structural violence perpetuated by dominant society that villainizes the Latina other. There is a continuous cycle being maintained, as the internal feeds into the external and the external feeds back into it. History, for example, both provides negative female experiences from which to theorize feminist thought from, but it also serves to inform negative social constructions of Latina bodies that are then internalized and regurgitated in a different form. Questioning the very notion of choice when it comes to a reproductive health procedure such as sterilization both coincides with the goal of the reproductive justice agenda to expand definitions of reproductive agency

and autonomy, but also utilizes the previously mentioned strategy of retheorizing the body in order to improve its social construction. A feminist science utilizes intersectionality to both address the repercussions of a history of abuse, while additionally dispelling the maintenance of stereotypes that serve an agenda that strays further and further from human rights.

CONCLUSION

The discussion of bodies is a delicate and complex undertaking, as unpacking social constructions calls for chipping away resilient histories of prejudices and its present day expressions. Control strategies play themselves out in various fashions, weaving into crevices of everyday life through institutions considered necessary for human survival. This notion of survival, however -- what it entails, how to achieve it -- becomes dangerous as it targets individuals in the name of protecting any chance of that survival. Targeting is achieved by categorization through systems of identity, which comes with a built-in hierarchical processes that assigns not only preference to certain identities, but also *worth*. The process of determining the worth of a human body is built into the construction of identities, a system whose definitions are never determined by the vulnerable. Seemingly invisible unless experienced, dehumanizing bodies that are labeled worthless, incompetent and threatening are socially constructed in a fashion that justifies and normalizes abusive physical handlings.

This logic is essential to understand when deliberating disparities in health for marginalized bodies. The barrier between science and social stigmas is either weak or does not exist, as is suggested when considering the medical treatment of Latina

reproduction. Rather than responding to female health conditions in a neutral, objective fashion, healthcare structures overwhelmingly support responsive practices that are heavily shaped by oppressive ideologies. If this project aims to expand definitions of Latina reproductive agency and autonomy, it also aims to expand definitions of sterilization abuse in support of scholars such as Lopez complicating binaries of reproductive choice.

Inadequate healthcare can generally be linked to two sources: institutional constraints and negative attitudes from healthcare professionals, each constructing and maintaining the other (Lopez 129). Both of these sources are explored within this project in the exploration of how race and ethnicity shape reproductive healthcare. If race, ethnicity, and gender all act as institutional constraints for the delivery of adequate reproductive healthcare for groups such as Latinas, then those some constraints invoke negative constructions of patients of a certain background, ultimately impacting and justifying inadequate reproductive healthcare. Thus, to discuss the issues within the structure of medical institutions, social constructions of certain types of bodies must also be discussed, as the two areas are inseparable from one another. In the case of reproductive healthcare, quality healthcare refers to ethical healthcare delivery that does not discriminate nor harm patients. As the history of Mexican and Puerto Rican women within the United States demonstrate, autonomy cannot exist without agency in the case of reproductive health. Practices and beliefs that restrict agency directly restrict the capability of autonomous choice, as negative stigmas around Latina identity and reproductive shape both individual and collective perspectives.

There is no singular Latina perspective on reproductive politics, as indicated by the stances different Latina grassroots organizations in the past (Silliman et al. 224) and few Latina specific reproductive organizations presently active. The approach to reproductive justice remains a collective effort amongst women of color all attempting to push for more intersectionality to be incorporated in medical structures. Loretta Ross, one of the larger names in the reproductive justice movement, says: "Our [women of color] ability to control whatever happens to our bodies is constantly challenged by poverty, racism, environmental degradation, sexism, homophobia and injustice in the United States" (147). Race, ethnicity and gender work in union to place Latinas in a position of vulnerability in which reproductive agency and autonomy are restricted. This restriction is both caused, justified and ultimately preserved through the persistence of theoretical othering of these bodies through social constructions lead to physical consequences. Expanding on the notion of sterilization abuse in relation to a framework built by combining Latina feminism and medical ethics puts intersectional thinking into action, paving the way for resistance -- or at least, pushing for further conversation around the very nature of reproductive rights/justice and the constructions that need to be challenged.

The sterilization of Mexican and Puerto Rican women provoke questions of ethical violations as do high rates of sterilization among Latina women. The absence of autonomy can be argued in all of these situations. Identifying the spaces in which autonomy lacks gives way to brainstorming about what Latina reproductive could and should look like. The intersectional application of care ethics in reproductive healthcare

implies restructuring the interactions between patients and those within healthcare institutions to address unequal distributions of power in these relationships. The nature of these relationships -- meaning patient and doctor, patient and society, etc. -- have a direct impact on how agency and autonomy play out. Restricting these two results from medical relationships/interactions that are guided by prejudices of race, ethnicity and gender.

Labelings Latinas as Others that are incapable of making responsible reproductive choices dehumanizes to deflect from the violation of medical ethics. As exemplified in the case of Mexican and Puerto Rican women, by being aggressively perceived as Others that required containment, these Latina women were dehumanized in order to make medical malpractice appear as humanitarianism. Ideas around gender, race and ethnicity assist in socially constructed othering that is eventually internalized, carrying itself throughout time. This process of construction Latinas as Others restricts the possibility of implementing an ethics of care that is so essential to generating a more intersectional notion of reproductive health.

To inhabit a body does not mean to own it. To inhabit a body does not ensure autonomy over that body. To inhabit a body bears little weight in the larger scheme of choice. To inhabit a body means to be part of a larger collective of bodies, who bear the burden of its existence. So is the reality of human bodies as they are categorized by sex, gender, race, ethnicity, class. As flesh is socially constructed in a manner that affects physical existence, we must ask ourselves: who truly decides in matters of the body? The answer lies in sorting through an accumulation of discriminatory societal ideologies, to uncover the potential of true, internal, autonomous choice.

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